USACHPPM

Army Health Connection

U.S. Army Center for Health Promotion and Preventive Medicine/Directorate of Health Promotion and Wellness Publication

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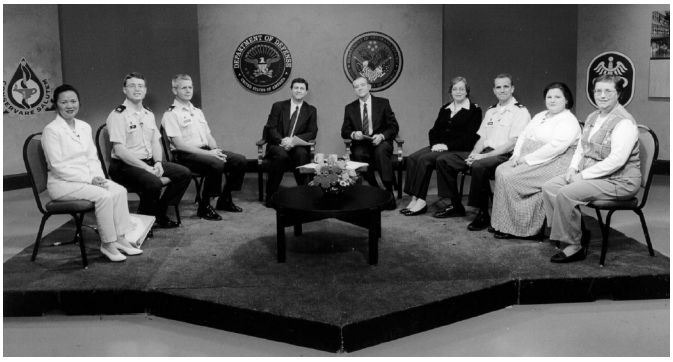
DOD/VA Clinical Practice Guidelines

By: LTC Kathryn J. Dolter, Chief, Outcomes Management Practice Guidelines Project Officer,
LTC Mary S. Lopez, Ergonomics Program Manager, USACHPPM and
Sean P. McDonald, Ergonomist, USACHPPM



Army medical facility representatives share their experiences with the low back pain guidelines.

Practice guidelines are mechanisms that ensure and improve the quality and cost-effectiveness of care provided in the Military Health System. They define the "right thing to do." Practice guidelines are best developed and implemented to standardize healthcare centrally, at the system-wide level. Guidelines are often confused with clinical pathways, defined as "the right way to do something." Pathways focus on improved utilization of resources and are best used locally at the facility-level. Once the "right thing to do" is defined by a guideline, pathways define the "right way to do" that "right thing."

The Army Medical Department (AMEDD) currently has two initiatives involving practice guidelines: the Department of Defense/Veterans Administration (DOD/VA) Clinical Practice Guideline Working Group and the AMEDD/RAND Corporation Practice Guideline Implementation Process Project. These AMEDD initiatives are assigned to the U.S. Army Medical Command (USAMEDCOM) Quality Management (QM) for coordination. Multidisciplinary panels of physicians and allied healthcare providers are the backbone of the clinical practice guidelines adaptation and implementation efforts described below.

The AMEDD has the lead of the DOD/VA Practice Guideline Working Group. In June 1998, the Working Group began to develop a practice guideline working group charter, select guideline topics, coordinate the adaptation of guidelines by expert clinicians from all services and the VA, coordinate the selection of guideline process and outcome metrics by expert clinicians, and develop a process

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The purpose of this newsletter is to offer practical information for the health promotion practitioner. It is not intended to provide medical advice on personal health matters, which should be obtained directly from a physician. The mention of any private entity in this newsletter is not to be deemed or to be construed in any way as official Army endorsement of same. Reproduction of this newsletter is encouraged.

DOD Guidelines, continued from page 1

of monthly collection and quarterly reporting of metrics to the DOD/VA Executive Council.

The guidelines topics selected for fiscal year were tobacco cessation, low back pain, hypertension, acute myocardial infarction, asthma/chronic obstructive pulmonary disease (COPD), hyperlipidemia, diabetes, and depression. Selection of topics was based on high-volume, high-cost diseases/conditions common to all four services (VA, Army, Navy and Air Force).

The FY 2001 topic selection includes substance abuse, gastro-esophageal reflux disease, post-deployment health issue evaluation, normal pregnancy, and pain management cancer. The Working Group will also focus on the prioritization of metrics for clinical preventive services in FY 2001. The VA and the Army have also partnered for the development of a pscyhoses guideline. The Chief Consultant to The Surgeon General (TSG) coordinates with the other consultants to TSG in the selection of the multidisciplinary panels of "champions" to adapt each guideline within the federal system. The Outcomes Management (OM) Branch, QM Directorate, is responsible for coordinating the AMEDD clinical consultant participation in the guideline adaptation conferences, staging select guideline adaptation conferences, implementing the completed guidelines in the AMEDD, and coordinating the DOD/VA Practice Guidelines Working Group meetings.

Guideline adaptation conferences have been held on low back pain, tobacco use cessation, hypertension, asthma/COPD, diabetes, depression, ischemic heart disease, and hyperlipidemia. All FY 1999 guidelines have been completed except ischemic heart disease, which is pending finalization.

The AMEDD has a concurrent project with the RAND Corporation to develop the best method for implementing the adapted DOD/VA practice guidelines within the AMEDD. The U.S. Army Medical Command QM and the Center for Healthcare Education and Studies (CHES) are working with RAND to develop a guideline implementation process for use by AMEDD military treatment facilities (MTF). The CHES provides strategic support, while USAMEDCOM OM is involved in all strategic and operational aspects of the initiative. The current plan for implementation of guidelines will be via development of a guideline implementation toolkit and modeling of the guideline implementation process for each MTF.

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Director's Corner COL Catherine Bonnefil

Recently, I had the opportunity to attend the 11th Annual American Journal of Health Promotion Conference. As the premier civilian forum of its type, it provided a unique opportunity to look at the evolution of health promotion from a different (corporate) civilian point of view. Just as important was the exchange of ideas with conference attendees about the future of health promotion.

I found some parallels between military and corporate trends in health promotion:

➥ Targeting to and tailoring for individuals/ populations at risk. Efficiently identifying and effectively allocating scarce resources against the "big rocks" (major health risks) in a given population is one of the main, hoped-for outcomes to be achieved through use of the Health Enrollment Assessment Review. This tool, utilized upon enrollment into TRICARE Prime and periodically thereafter, is generating a significant database for our eligible beneficiary population. Unfortunately, it will remain inaccessible to members of the Reserve Component until a web, paper, or phone-based version enables their access. Also, the clinical application of this data for effectively

COL Catherine Bonnefil

and systematically managing individual preventive care (through Put Prevention Into Practice [PPIP]) is hampered by competing priorities within the clinical arena.

➥ Increased use of technology. At the conference, development of interactive websites was highly visible from sponsors such as the Mayo Clinic. In both civilian and military spheres, such websites offer great potential to reach geographically diverse populations. In this arena, the Army is on a par with, and will soon surpass, our corporate counterparts. This will be evident with the establishment this spring of the U. S. Army Center for Health Promotion and Preventive Medicine's state-of-the-art Hooah-4-Health website. This is an interactive, incentivized, stages-of-change-based health promotion program, which is being developed to reach and improve the health readiness status of members of the Reserve Component.

Our society has long been mesmerized by hi-tech solutions. In his keynote address, Dr. Dean Ornish stated the obvious: that it is much more exciting to talk of quadruple bypass surgery than to focus on eating a low-fat diet, thereby avoiding the need for the surgery altogether. Applying this model as a metaphor in the development of health promotion, it seems inevitable that technology will play an increasing role in enabling us to "reach out and touch" people, thereby maximizing opportunities for the teachable moment.

In the midst of all the hi-tech hoopla, I sensed a growing low-tech counterbalance. From some speakers and in many private conversations there was an acknowledgement that, yes, technology as expressed in all multimedia formats, is great stuff. At the same time, the consensus is that the best delivery system of all remains person-to-person interaction. In the future of corporate worksites, "wellness coaches" may provide most of this one-on-one behavioral intervention.

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Guideline toolkit development includes bringing together focus groups of Tri-service providers to develop provider support, patient self-management support, system/system process support, and automated disease management informatics system/process tools. Provider support tools include documentation tools to streamline and standardize clinician documentation, continuing medical education videos, and provider point-of-care reminder cards. Patient self-management tools include patient self-care brochures, videos, and documentation tools to set goals and monitor progress. Process/system support tools include examples of implementation strategies and changes to the care delivery process, (i.e., utilization of ancillary staff); guideline metric measurement and feedback loops and corporate "best-buy" pharmaceutical and medical logistics items.

LTC Mary Lopez of USACHPPM describes the contents of the low back pain "Toolkit" for healthcare providers.

Toolkit development has been fully supported, and is now led by the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM). The Disease and Injury Control Program, Directorate of Clinical Preventive Medicine, coordinates focus groups with the condition clinical experts, and gathers the best practice tools available in the civilian and military sector. Then, based on consensus, patient self-management and provider point-of-care materials are piloted. The USACHPPM has expanded its role in support of USAMEDCOM through the production of satellite broadcasts for the system-wide implementation of guidelines.

Modeling of the facility and clinic-level implementation process is via facilitated MTF-level primary care team working group "kick-off" meetings within each region. At the "kick-off" meeting, each MTF's primary care team develops its process for implementing the guideline within their clinic. That process will be transferable to the implementation of any guideline.

This approach was piloted in the Great Plains Regional Medical Command (GPRMC) commencing in February 1999 after a "kick-off" conference held in November 1998. Lessons learned from the GPRMC implementation of the low back pain guideline were incorporated into a second pilot project involving the DOD/VA Asthma Guideline in the Southeast Regional Medical Command in September 1999 after a "kick-off" conference held in August 1999. The Northwest Regional Medical Command is piloting the DOD/VA Diabetes Practice Guideline in December as part of a TRICARE Region 11 "kick-off" initiative. Via a TRICARE Region 6/USAMEDCOM partnership, the Army and other DOD Medicare Subvention sites will be implementing the DOD/VA Diabetes Guideline at all sites in order to meet their mandated Diabetes Quality Improvement Program requirement. In February 2000, the Army piloted system-wide deployment of the low back pain clinical practice guideline utilizing satellite broadcast technology.

The work of the DOD/VA Clinical Practice Guideline Working Group continues. Guideline topic selection, adaptation, metric selection, and dissemination processes are continuously being improved. Through this collaboration, improvements in the quality of healthcare across the federal system will be achieved.

The DOD/VA guidelines can be accessed via the AMEDD's website at www.cs.amedd.army.mil/qmo, and the Air Force Population Health Support Office website at www.phso.brooks.af.mil. Guideline toolkit

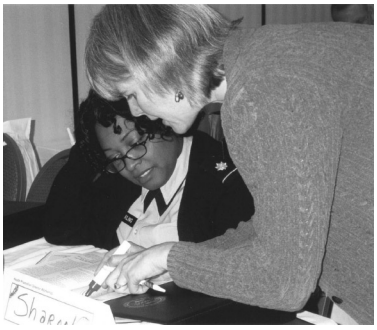
The Health Promotion Director Workshop 13-17 March 2000

The Health Promotion Director Certification Training Course, sponsored by the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) in cooperation with The Cooper Institute for Aerobics Research, continues to receive rave reviews.

Cooper Course attendees show workgroup pride.

This course is open to all three services and their reserve forces for those who hold a duty assignment in a health promotion or wellness-related field. The purpose of the week-long course is to develop basic skills and knowledge related to planning, implementing, and evaluating comprehensive health promotion programs.

Thirty-seven health promotion professionals attended; including participants from Hawaii, Germany, and Italy bringing the number of participants who have been trained throughout this course to over 400 since 1995. Participants received over 37 continuing education units. The topics included needs assessments, writing business plans, obtaining resources, budgeting, marketing, and program evaluation. Subject Matter Experts from USACHPPM augmented the course by providing lectures on: Nutrition, Managed Care, Budgeting, Stress Management, Suicide/Spirituality, and Marketing.

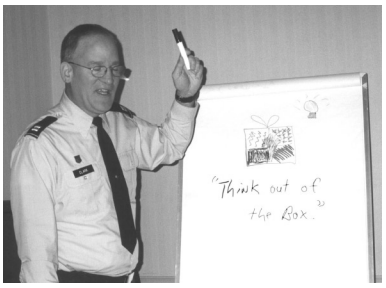


MAJ Sharon Sterling gets help from Susan Watts on program development.

Lecture and discussions were reinforced by hands-on exercises and group work. Special emphasis was placed on current health promotion programs and resources within the military system.

Participants were impressed by the practical information contained in the course. Most agreed it was the most useful and the best health promotion training they had ever attended. The following quotes were evidence of the participants' thoughts about the course:

- "Crème de la crème of courses"
- "I really appreciated the teaching tactics and availability of instructors"
- "The networking opportunities were super"
- "Excellent instructors"
- "Enjoyed the logical progression of the course"
- "Instructors were always willing to take the time to help you understand and available to answer questions off-line"
- "Great use of small group and interaction with participants"



CPT Michael Clark preaches "thinking out of the box."

Following successful completion of a take-home examination, the Cooper Institute certifies each participant as a Health Promotion Program Director. The next Health Promotion Director Workshop may be sponsored by the USACHPPM in early 2001. For further information, contact Education and Training Service, Directorate of Health Promotion and Wellness, at DSN 584-4656 or commercial (410) 436-4656.

Health Promotion and Prevention Initiatives (HPPI) FY 2000 Competitive Funding Results

By: Brad A. Taft, R.N., M.S.

Identifying "best practices" to improve and protect the health of our most valuable resource, the men and women of the U.S. Army, is at the core of the Health Promotion and Prevention Initiatives (HPPI) Program. The HPPI Program is sponsored by the Army Medical Department (AMEDD) and executed by the Directorate of Health Promotion and Wellness (DHPW) at the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM).

For FY 2000, the AMEDD allocated funds for the HPPI Program to continue the identification of "best practices" for health promotion and the prevention of disease and non-battle injury (DNBI). Health Promotion and Prevention Initiatives Program executed a rigorous competitive funding process to allocate these resources to proposals demonstrating the potential to become "best practice" in the AMEDD.

This year, each proposal application included three new sections that will provide essential data for program evaluation: (1) Project Impact Matrix, (2) Project Evidence Matrix, and (3) Project Action Report. The impact matrix identifies key elements of the project's impact on the target population. The evidence matrix identifies key quantitative aspects of program effectiveness. The action report critiques the project activities.

Health Promotion and Prevention Initiatives Program proposals were solicited in mid-January, received by 19 February, and then entered into the HPPI database. After this, proposals were scored by subject matter experts, and ranked by an expert consensus panel for final resourcing. Of 65 proposals received, 24 were selected to receive funds for implementing the proposed initiative. Along with the resources came the expectation that outcome and evaluation measurements will be collected and sent to DHPW for further analysis. Each funded proposal is accountable to provide evaluation data to the HPPI Program utilizing the metrics described in the funded proposal. From this data, HPPI will identify effective interventions that may become "best practice" standards in the AMEDD.

Funds for FY 2000 HPPI proposals were allocated in accordance with the competitive funding process described above, as well as according to the focus areas specified in the HPPI FY 2000 request for proposals, the strength of the HPPI portfolio in a proposal content area, and the execution of HPPI funds at specific installations in prior funding cycles. The HPPI portfolio consists of eleven content areas: (1) Behavioral Health/Symptom Management, (2) Comprehensive Health Promotion and Prevention, (3) Injury Prevention, (4) Maternal Child Health, (5) Nutrition and Weight Control, (6) Oral Health, (7) Physical Fitness, (8) Spiritual Health, (9) STD and HIV Prevention, (10) Stress Management and Suicide Prevention, and (11) Tobacco Cessation.

Continued on next page.

FY 2000 Funded HPPI Proposals by Content Area

Content Area	Proposals Funded
Behavioral Health/Symptom Management	1
Comprehensive Health Promotion and Prevention	5
Injury Prevention	4
Maternal Child Health	1
Nutrition and Weight Control	5
Oral Health	4
Physical Fitness	0
Spiritual Health	0
STDs and HIV Prevention	1
Stress Management and Suicide Prevention	2
Tobacco Cessation	1

HPPI information is posted regularly on the worldwide web. Please go to **http://chppm-www.apgea.army.mil/dhpw/** then click on **Health Promotion and Prevention Initiatives**.

Depression, the Common Cold of Mental Illness

By: LTC Nancy Chapman, Behavioral Health Service

Depression has been dubbed the common cold of mental health. Steven Paul, Chief of Clinical Neuroscience at the National Institute of Mental Health states, "Depression is like a fever. It's a nonspecific response to an internal or external insult. Like fever, it has a number of origins and treatments."

"Depression is like a fever. It's a nonspecific response to an internal or external insult. Like a fever, it has a number of origins and treatments."

In the United States, about 10 percent of the population (7 percent women and 3 percent men) meet the criteria for major depression, and another 4 or 5 percent undergo a depressive experience that is not sufficient to be officially classified as clinical depression. Depression is an expensive illness, costing the American society about $44 billion in lost workdays, poor job performance, and psychotherapeutic care. Although the financial consideration is significant, the personal costs are incalculable. Depression is more isolating and debilitating than any other chronic illness. During their lifetime, nearly one fourth of all women will suffer major depression.

In the 1998 Department of Defense Survey of Health Related Behaviors Among Military Personnel, 18.9 percent of the Army members surveyed screened positively for depressive symptoms. This screen indicated that these soldiers were "in need of further evaluation for depression." Depression was addressed in a keynote at the American Society of Surgeons meeting in November 1998, indicating an increasing concern for depression in military personnel. Listed as one of the top 20 health concerns, a Veterans Administration/Department of Defense working group was established to develop a practice guideline for primary care physicians. The

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guideline is anticipated to be adopted shortly throughout the military. Clearly, depression is a growing concern.

What is major depression? The American Psychiatric Association and Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition classifies it as a mood disorder when at least ***five*** of the following symptoms occur within the same two-week period and represent a key change from previous functioning:

- a depressed mood most of the time (at least two weeks)
- apathy
- a significant weight loss or weight gain
- a significant change of sleep habits
- a marked decrease in mobility
- feelings of worthlessness
- a diminished ability to think or concentrate; indecisiveness
- excessive fatigue/loss of energy
- excessive guilt
- recurrent thoughts of death
- general suicidal ideas or a concrete suicidal plan/attempt

Depression is a huge challenge to the medical system. According to the book, Mind, Body Health, by Hafen, Karren, Frandsen, and Smith, approximately one-fourth of all the primary care medical patients come from the 15 percent of the population with major depression and anxiety disorders. If minor depression and anxiety-related issues are included, this figure climbs to almost half of all the patients who present to health care facilities for treatment. (Depression and anxiety are combined here because they frequently overlap and have neurochemical similarities.)

Depression and anxiety generate many physical ailments. Patients present with complaints of physical problems. They are often treated only for their physical concerns, and not questioned about potential psychological factors that may be the underpinnings of the symptoms. Only about one third are recognized and treated for their primary concern, perpetuating costly patient return rates. Effective identification and treatment of depression have been proven to greatly reduce the unnecessary suffering, employment absence, costs of ongoing treatment, and associated medical illness.

The good news is that more than 80 percent of the people who do undergo treatment for depression experience a significant improvement within just a few months. New medications effectively alleviate symptoms with minimal, if any, side effects. The most effective treatment for major depression is the combination of psychotherapy and medication. Although there are many types of psychotherapy available; but studies on treating depression primarily support two types: cognitive behavioral therapy and interpersonal therapy. The key for depression, as in most diseases, is early detection followed by swift and effective intervention.

An interview with Greg Tamblyn, musical keynote speaker for the Force Health Protection Conference

By: LTC Nancy Chapman, Behavioral Health Service

AHC:
What is a musical keynote?

Greg:
It's a keynote presentation that features songs to illustrate the ideas. Most speakers use stories and sometimes jokes to expand their message and to connect with the audience. I use them too, but I really feature funny and serious songs, as a different way to give a message.

AHC:
You clearly weave humor into your message through song. How do you see humor as being helpful in conveying a message of health?

Greg:
I see humor as being helpful in conveying a message of LIFE. What is life without humor? Plus, humor is like music — it gets to a different part of the brain. And now we have all these studies that attest to the healthful benefits of humor, of laughter, really. If you can laugh about something serious, it puts it more into perspective.

AHC:
Greg, How do you describe what you do?

Greg:
I'm sort of an idea collector, an idea synthesizer. I used to write love songs in Nashville. But I became interested in wellness and ways to live more effectively, and the music just sort of followed along. I write what I call "Life Songs." These are usually about some idea, some "guidepost," that helps us down the road of life, or some "roadblock" that holds us back.

AHC:
Like what?

Greg:
Like the things that have helped me get through life: optimism, friendship, gratitude, connection, laughter, humor, self-awareness, universal love, feeling a part of some mystery greater than myself. Chris, the D.J. on "Northern Exposure," said, "Happiness isn't having things. Happiness is being part of things."

AHC:
Greg, what do you think are some "roadblocks to achieving a more effective life?"

Greg:
Roadblocks can be things like control issues, raging egos, victim mentality, having to be right all the time, hostility, out-of-control Type-A personalities, self-doubt, family issues, relationship issues, and even the effects of our culture on our psyches. Music is the way I can take serious issues that can adversely affect our lives, and present them in a manner that makes it possible, (hopefully, likely), to see them as hilarious, once you step back and look at it. Awareness is the first step of change in the self-improvement area.

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Highlights from the upcoming

3rd Annual Force Health Protection Conference

7-11 August 2000
Baltimore, Maryland

(See Conference Update on page 19 for more information.)

Be The Person Your Dog Thinks You Are

(A Musical Keynote)

Healthcare providers and attendees will learn via songs, stories, and a lot of humor how certain psychological tendencies (e.g., the need to control, victim consciousness, the tendency toward hostility) can affect relationships in the workplace and home. They will learn how humor and songs can expand awareness of these issues in themselves, coworkers, and patients/clients as well as be validated for taking care of their own needs as caregivers. This will be a novel and entertaining keynote and learning opportunity that you won't want to miss. (See Interview with Greg Tamblyn on page 9.)

Greg Tamblyn

Alternative Medicine

Dr. Low Dog, Tree House Center of Integrative Medicine

This workshop will address 12 commonly used herbs in the U.S. market including research, possible benefits and health risks, as well as dosage. Dietitians are being asked more and more about herbal medicines by their clients, making this presentation a valuable introduction to the topic. This workshop will conclude with a discussion on the military application of supplements and herbal medicine for Army dietitians and other Army healthcare professionals.

Susan Watts, The Cooper Institute

Marketing Health Promotion to the Line

This seminar will look at marketing techniques, identifying the needs of the line commands and connecting the benefits of health promotion programs to the bottom line-readiness. This interactive session is designed to provide a working knowledge of marketing from assessing the needs of the line command, defining the line commander's hook, to creating an impact scenario that supports a strategically responsive force. A panel of military officers and Commanders will wrap-up this workshop addressing any questions or comments that participants have about marketing health promotion to the line.

COL Jim Greenwood, USAG Commander

Greg Tamblyn, continued from page 9

AHC:
Can you give us an example of a song about a "roadblock?"

Greg:
I have a song called "The Shootout at the I'm OK, You're OK Corral" that's about an argument between a husband and wife where all they do is yell titles of self-help books at each other instead of really communicating. This is a roadblock, even though we all may engage in it at times, it's not a very effective manner of living.

AHC:
So how did you become interested in living more effectively?

Greg:
I was basically dragged, kicking and screaming, down the path of self-awareness, self-responsibility, personal growth, emotional maturity and responsibility. At an earlier time in my life, I was in much pain and denial about who I was. On top of it all I ruptured my spleen. As I was recuperating from that – writing new songs, healing my spleen — a new career path emerged. I began to get invited to sing at places that I'd never dreamed about: medical conferences, corporate wellness events, health promotion conferences, addiction recovery conferences, hospitals, schools, and so on. It's been a fun and challenging career. The great thing is that I'm always getting exposed to new ideas that frequently become songs.

AHC:
Can you give us an example?

Sure. I wrote a song after reading about Evy McDonald, the first and only one of the few persons to ever recover from Lou Gehrig's Disease. She basically healed herself by deciding to learn how to love herself before she died. Twenty years later she's still going Strong – an amazing example of mind-body medicine.

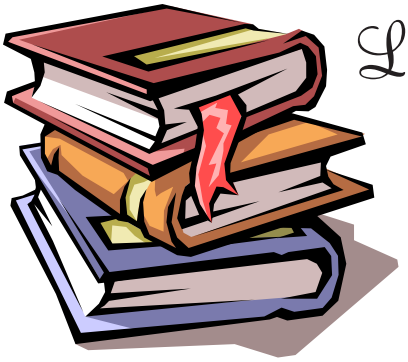
AHC:
So what will you be doing for us at the conference?

Greg:
I think we'll have some fun with some of these things we've been talking about, and see how they relate to wellness. I am really looking forward to playing for the conference and hope you will all come out for the musical keynote at the conference on Thursday.

AHC:
Where do you go from here? Where do you see yourself in five years?

Greg:
Boy, I don't know. When you've played for the Army, you've pretty much reached the pinnacle. It's kind of all downhill from there, don't you think!

Greg Tamblyn will be presenting a musical keynote at the Force Health Protection Conference from 3:30 to 4:30 PM on Thursday, August 10.



Literature Reviews

The Gist of GIS (Geographic Information Systems).
Goldman, Karen D. and Schmalz Kathleen J.
Health Promotion Practice, January 2000/Vol 1, No.1, 11-14.

Review by:
MAJ Angie Hemingway

This article, which was written by a nurse and health educator, suggests that knowledge of Geographic Information Systems (GIS) use is rapidly becoming essential. Geographic Information Systems is an educational research tool used for complex spatial analysis and computer mapping. The authors explain that when Dr. Snow, the London physician, decided to plot the location of cholera victims' homes on a map, he was using the modern day form of GIS. Geographic Information Systems as it stands today is within the reach of almost anyone with minimal basic computer skills. Geographic Information Systems can be used for research, teaching, and advocacy. Healthcare personnel are just beginning to see the value of GIS. Other disciplines have used GIS to track customer sales, analyze crime patterns, route delivery trucks, display soil types, find the best location for an expanding business, and much more.

To execute GIS, the user will need data which provides an abstracted version of the real world and specialized GIS software. The user will further need to decide on the study methodology, the project design, the relative importance of variables, the interpretation of the results, and the dissemination of the findings.

The authors gave excellent examples of how health promotion and preventive medicine personnel might use GIS to investigate public health issues. Geographic Information Systems can enable decision makers to make better decisions about allocating funds and can help improve access to health care and education.

Investigating a communicable disease outbreak is one example of how GIS can be used by a Community Health Nurse or Preventive Medicine Provider. The authors indicated that if Salmonella was the suspected infection, the home and work addresses of all persons admitted to the Medical Treatment Facility or treated with a Salmonella symptom would be plotted on a map. By relating clustered salmonella cases for restaurant locations within a 15-minute driving distance of the clustered cases, possible Salmonella infection restaurant sources could be pinpointed. Implications for preventive medicine and community health nursing are: gathering, organizing and sharing information with appropriate agencies and organizations to prevent further spread of the source of infection. Furthermore, they may develop primary, secondary and, tertiary prevention community/health education interventions.

The article points out that, while GIS will assist in exploration, it will not suggest prevention strategies. Researchers and decision makers will still need to analyze and interpret the data and then come to their own conclusions regarding courses of action.

The authors offer the following references to individuals who may want to learn more about this exciting tool:

Dorling, D. & Fairbairn, D. (1997). Mapping: *Ways of representing the world.* Essex, UK: Addison Wesley Longman.

Continued on page14

Gist of GIS, continued from page 13

Clarke, K. (1997). *Getting started with geographic information systems*. Englewood Cliffs, NJ: Prentice Hall.

Software suggestions:
ArcView, a desktop, PC-based software package for mapping health care issues, Environmental Systems Research Institute, Redland, CA.

MapInfo.

Quality Internet Health Care Resources

Manwick, Charles. (2000). Ensuring ethical internet information. *Journal of the American Medical Association, 283*, 1602-1606.
Review by: Carlla E. Jones, Evaluations and Outcomes, DHPW

At least 15,000 World Wide Web sites carry health and medical information, which to this point has been subjected to little regulation. The Internet Healthcare Coalition, (IHC), an international nonprofit organization, is working to remedy this situation and ensure that only accurate information about health and medical care is disseminated on the Internet. A draft ethics code has been prepared; initial public comments were accepted until 15 April. Final publication of the "e-Health Code of Ethics" is slated for mid-May.

The e-Health Code aims to "ensure that all people worldwide can confidently, and without risks, realize the full benefits of the Internet to improve their health." Five main subject areas are addressed in the Code: candor and trustworthiness; quality; informed consent, privacy, and confidentiality; best commercial practices; and best practices for provision of health care on the Internet by health care professionals.

John Mack, president of the IHC, acknowledges that policing *all* Internet sites with health information is impossible. The "bad guys," who will never abide by any code of ethics, are a real problem. However, 80% of the people seeking health information on the Web visit just 20 to 30 sites, out of the total of 15,000 Internet sites with health related information. In the future, a "seal of approval" may be one way to alert consumers to a Web site's accuracy and conformity to the IHC code. Internet search engines may also "flag" sites conforming to the IHC code with a special marker, as well.

More information about the IHC and the e-Health Ethics Initiative may be found at http://www.ihealthcoalition.org/.

On The Web

http://www.nal.usda.gov/fnic/

The Food and Nutrition Information Center (FNIC) is one of several information centers at the National Agricultural Library, sponsored by the United States Department of Agriculture (USDA). It has resource lists and databases as well as other food and nutrition related links. It also hosts a "What's New in…" section on current food/nutrition issues, such as conferences; FNIC publications; dietary supplements, food labeling, Food and Drug Administration (FDA) approvals/updates; general nutrition; and USDA articles, reports, and studies. The databases include listings of nutrition software and multimedia programs, educational materials, and training programs. Other sections in this site address the food guide pyramid, food safety, dietary supplements, dietary guidelines, and healthy school meals and food composition.

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Soldier's Corner

Prevention of Heat-Related Injuries

Replace water loss frequently even if you are not thirsty. Refill your canteen at every opportunity. Do not consume more than 1-1/2 quarts/hour or 12 quarts/day.

Watch the Wet-Globe Bulb Temperature. Use the chart below to determine work/rest ratios, and water intake.

Acclimatize to the heat slowly, over a 7-14 day period. Gradually increase your physical activity in the heat.

Maintain good physical condition. Susceptibility to the heat is increased by overweight, fatigue, illness, infections, and fevers.

Wear lightweight clothing that permits good air circulation and enhances evaporation of sweat (for cooling). Keep skin covered to avoid sunburn. If commanders permit, unblouse your boots and unbutton your BDU jacket.

Avoid excessive exposure to the sun and wear a sunscreen on exposed body parts. Use a sunscreen with a skin protection factor (SPF) of 15 or higher (30 if you have fair skin).

Participate in training on preventing, recognizing, and treating heat injuries.

Fluid Replacement Guidelines, Warm Weather Training (Average Acclimated Soldier Wearing BDUs)[a]

Heat Category	WBGT Index (°F)[b]	Easy Work (see examples)		Moderate Work (see examples)		Hard Work (see examples)	
		Work/Rest[c]	Water Intake (qt/hr)	Work/Rest[b]	Water Intake (qt/hr)	Work/Rest[b]	Water Intake (qt/hr)
1	78-81.9	No Limit	½	No Limit	¾	40/20 min	¾
2 (Green)	82-84.9	No Limit	½	50/10 min	¾	30/30 min	1
3(Yellow)	85-87.9	No Limit	¾	40/20 min	¾	30/30 min	1
4(Red)	88-89.9	No Limit	¾	30/30 min	¾	20/40 min	1
5(Black)	>90	50/10 min	1	20/40 min	1	10/50 min	1

[a] Work/rest times and fluid replacement volumes will sustain performance and hydration for at least 4 hours of work in the specified heat category. Individual water needs will vary by +/- ¼ quart.

[b] Wearing MOPP gear adds 10°F to WBGT index

[c] Rest means minimal physical activity (sitting or standing) and should be accomplished in the shade if possible.

Examples of Easy, Moderate, and Heavy Work:

Easy Work	Moderate Work	Hard Work
Road marching on a hard surface at 2.5 mph with <30 lb load Weapons maintenance Manual of Arms Marksmanship training Drill and Ceremony	Walking on a hard surface at 3.5 mph with <40 lb load Walking on loose sand at 2.5 mph with no load Calisthenics Patrolling Individual movement techniques (i.e, low or high crawl) Defensive position construction Field assaults	Walking on hard surface at 3.5 mph with >40 lb load Walking on loose sand at 2.5 mph with a load

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Types and Symptoms of Heat-Related Injury

Sunburn – Reddening of the skin with pain on movement or touch. Blisters may occur in severe cases.
Heat Cramps – Muscle cramps (in extremities or abdomen), excessive sweating (wet skin), thirst.
Heat Exhaustion – Symptoms occurring often: excessive sweating, headache, weakness, dizziness, loss of appetite. Symptoms occurring sometimes: heat cramps, nausea, urge to defecate, chills (gooseflesh), rapid breathing, tingling of hands and/or feet, confusion.
Heat Stroke – Usually, casualty has been working in a hot, humid environment. Hot and dry skin, weakness, dizziness, confusion, headaches, seizures, nausea, breathing problems, loss of consciousness.

First Aid for Heat-Related Injury

Sunburn – Cover the body part. Apply cold compresses or lotions for pain relief.
Heat Cramps – Move casualty to shade; loosen clothing (except in chemical environment). Provide at least one canteen of cool water. Monitor casualty, providing more water if tolerated. Seek medical attention if cramps continue.
Heat Exhaustion – Move casualty to shade; loosen clothing (except in a chemical environment). Pour water over casualty and fan to cool. Have casualty drink at least a canteen of cool water. Elevate casualty's legs. Seek medical attention if symptoms continue. Monitor casualty until symptoms are gone or medical help arrives.
Heat Stroke – This is a medical emergency. Move casualty to shade; loosen clothing (except in a chemical environment). Cool casualty with ice packs or cool water. Elevate legs, massage extremities. Have casualty drink water. Seek medical attention ASAP and continue cooling casualty while awaiting medical evacuation.

References

Field Manual 21-10-1. Unit Field Sanitation Team. Washington DC: Department of the Army, 1989
Field Manual 21-10. Field Hygiene and Sanitation. Washington DC: Department of the Army, 1988
Field Manual 21-11. First Aid for Soldiers. Washington DC: Department of the Army, 1988
Ramsey ML, Wappes JR. Soothing your summer skin problems. Physician Sportsmed 26(7):75, 1998.
Montain SJ et al. Fluid replacement recommendations for training in hot weather. Military Medicine 164:502, 1999

POC: Dr. Joseph Knapik DSN 584-1328

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http://navigator.tufts.edu/

The Tufts University Nutrition Navigator: A Rating Guide to Nutrition Websites is an online rating and review guide for users seeking nutrition information from web sites. A panel of leading U.S. and Canadian nutrition experts developed the rating and evaluation criteria. Instructions are provided on how to use this site. Topic areas include: general nutrition, parents, children, women, journalists, health professionals, educators, and special dietary needs. Each web site listed under a topic area receives a rating score that ranges from "among the best" to "not recommended" based on a 25 point rating scale in the areas: Nutrition Accuracy (10 points), Depth of Nutrition (7 points), Site Last Updated Information (3 points), and Usability (5 points).

Consolidated Troop Medical Clinic (CTMC) Basic Trainee Self-Care Intervention Program

General Leonard Wood Army Community Hospital's Basic Trainee Self-Care Intervention Program was developed and implemented three years ago. Since its implementation, nearly all basic trainees attending their initial military training on Fort Leonard Wood have attended this class. The class, which provides our vision of health as a multi-factorial (encompassing physical, mental, emotional and spiritual factors) to these young men and women, is usually taught during the first week of basic training. The basic goals and objectives of this program include: promote and develop healthcare consumer skills, advance the philosophy that personal healthcare is a joint responsibility of the basic trainee and the military healthcare system, reduce the demand for non-urgent, self-treatable conditions, and reduce the time lost during basic training to seek healthcare.

A trial study was performed late in 1996 using pretest-treatment-posttest instruments. A control group was also followed which received no self-care education and continued to use the CTMC as usual. Results of this study indicated that the basic trainees did not spend as much time within the CTMC and were returned to training more quickly. Indicators of satisfaction provided by the basic trainee themselves showed that the majority believe this program made them wiser healthcare consumers and was a valuable benefit of Army service.

The Self-Care class empowers the basic trainee to become more responsible for his or her own health. In addition to the philosophical aspect as mentioned above, we teach students basic identification of non-urgent medical conditions. If the basic trainee so chooses, he or she may ask permission to attend the self-care option for medical care. The basic trainee completes a form describing their condition and then may ask for simple, over-the-counter (OTC) medications for treatment. If the reviewing pharmacist agrees, the basic trainee receives the requested medication and returns to his unit. If the screening medic or pharmacist disagrees, the basic trainee is placed into the regular CTMC lines.

Using this program we have been able to begin education of the new soldier on matters relating to health and the Army Medical Department from the soldier's initial entry onto active duty. The basic trainee's eight-week schedule of basic training leaves little slack time – this program returns the basic trainee to his regular training as soon as possible. In addition, the CTMC personnel can now provide increased emphasis to those basic trainees who truly have more urgent conditions.

Over 21,000 basic trainees received our self-care education training in 1999. These soldiers are now stationed throughout the world. We hope the process begun at Fort Leonard Wood has given you a soldier healthier and more knowledgeable about health than previously seen. For more information on the Basic Trainee Self-care Intervention Program please call: Major Steven R. Morse, Chief, HPC; Ms. Cindy Plank, Health Educator, HPC; or SFC Deborah Ahern, NCOIC, HPC.

Steven R. Morse, MAJ, AN
Chief, Health Promotion Center
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The best military model for this high-touch approach can be found in the PPIP Program, in which the Primary Care Manager (PCM) gives direction to primary prevention, but in which other members of the primary care team also interact with the patient in ways which complement the PCM and accomplish the most time-intensive aspects of prevention counseling.

➥ Growing awareness of social factors as impacting on health. Reflecting the theme of the conference, many presentations focused on the powerful impact of social factors, such as social networks and secure, warm relationships in protecting and improving health status. Research documents that people who live in such supportive surroundings usually make healthier life choices; consequently, they are less likely to have angina, ulcers, and impaired immune function. If they do become ill, they demonstrate considerably more resiliency than those without good support systems. From the military perspective, many current and recent military leaders, such as former Chief of Staff of the Army, General (RET) Gordon Sullivan, have recognized the importance of culture/climate as a force multiplier. Our own Evaluation and Outcomes Service is beginning to look at some of the "antecedents to health status" and their relationship to population health management.

While recognizing the potential impact of technological advances, it is incumbent upon all of us who work in health promotion to remember that technology may be changing the way people live, but technology alone will not change their health habits. Most at-risk individuals will require personal intervention at some level. In addition, an awareness of social factors as a prominent influence on personal behavior choices needs to be further explored, defined, and factored into our health promotion programs.

"Healthwatch" Gets Award

Washington, D.C. - ***Army Healthwatch*** received the 2000 Telly award for excellence in medical television information programming. ***Healthwatch*** is the U.S. Army Center for Health Promotion and Preventive Medicine's (USACHPPM's) health, fitness and preventive medicine video news program seen in Army medical centers, hospitals and clinics across the United States and on 367 civilian television stations and cable systems. In announcing the awards, Executive Director David Carter said "entries do not compete against each other. Rather, they are judged against a high standard of broadcast excellence. This year there were over 12,000 entries nationally and only 14 percent received an award." ***Healthwatch*** had previously captured a 1999 Department of the Army Keith L. Ware award and was a finalist in Time-Life's 1999 International Health and Medical Film competition.

Healthwatch programming is available in 59 Army Medical Treatment Facilities. "It's a great key component of our patient education and patient relations program" according to CPT August Schomburg, former commander of the Presidio of Monterey Army Health Clinic. One patient seen in that clinic, Navy pilot LCDR Eric Patten, requested and received a copy of the program to use in the flight school classes he teaches. The program is currently produced quarterly. The USACHPPM plans to expand distribution of the program overseas this year.

For More Information Contact: COL Paul Little, (703) 325-5541

Conference Update

CDC 2000 International Conference on Emerging Infectious Disease
Dates: July 16-19, 2000
Location: Marriott Marquis Hotel, Atlanta, GA
Contact: Charles Schable / Peter Drotman
TEL: 404-639-4583/404 639-4018
FAX: 301-694-5124
E-mail: cas1@cdc.gov or dpd1@cdc.gov
Web Site: http://www.cdc.gov/ncidod/iceid/index.htm

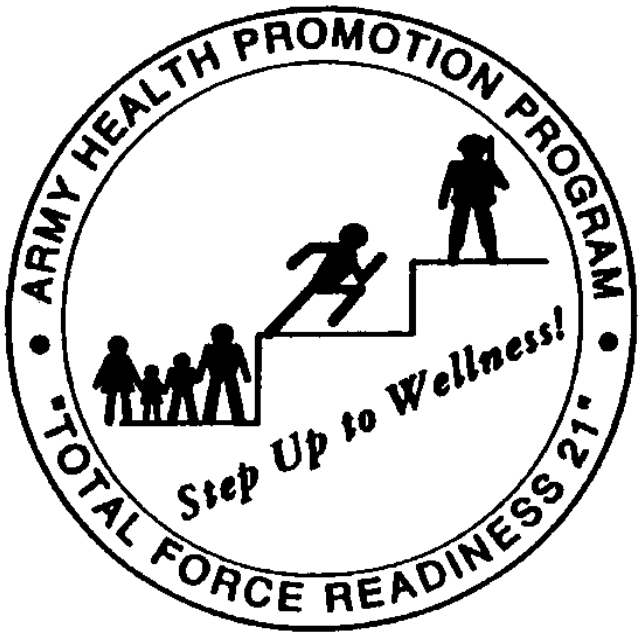
3rd Annual Force Health Protection Conference
"Force Health Protection for the New Millennium"
Dates: August 7-11, 2000
Location: Baltimore Convention Center, Baltimore, MD
TEL: 410-436-8139
FAX: 410-436-4158
Web Site: http://chppm-www.apgea.army.mil/dhpw/

National Center for Health Statistics Data Users Conference
Dates: July 26-29, 2000
Location: Hyatt Regency Bethesda, Bethesda, MD
Contact: Pat Drummond
TEL: 301-458-4193
FAX: 301-458-4022
E-mail: pad1@cdc.gov
Web Site: http://www.cdc.gov/nchswww/

National Occupational Injury Research Symposium 2000
Dates: October 17-19, 2000
Location: Sheraton Station Square Hotel, Pittsburgh, PA
Contact: Judy Fields/Louis Smith
TEL: 304-285-5900
FAX: 304-285-6047
E-mail: nas5@cdc.gov
Web Site: http://www.cdc.gov/niosh/noirs2000.html

11th World Conference on Tobacco OR Health
Dates: August 6-10, 2000
Location: Chicago Hilton and Towers, Chicago, IL
Contact: Anne Jenkins
TEL: 312-464-5159 or 312-464-9059
FAX: 312 464-4111
E-mail: 11thWCTOH@ama-assn.org
Web Site: www.wctoh.org

128th Annual Meeting of the American Public Health Association
"Eliminating Health Disparities"
Dates: November 12-16, 2000
Location: Boston, MA
TEL: 202-777-APHA
FAX: 202-777- 2534
Email: edward.shipley@apha.org
Web Site: http://www.apha.org/meetings/



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